ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO SHARE MEDICAL INFORMATION

Date ______________________________ **Patient Name** ____

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

____ ____
Signature of Patient or Personal Representative **Print Name of Patient or Personal Representative**

____
Description of Personal Representative's Authority

Contact Information for Personal Representative:

Address:

____

____

Phone Number:

____ ____
Daytime **Evening**

I authorize Mid Florida Hematology and Oncology Centers, P.A. to share my medical information with the following:

Name	Relationship	Phone Number

This authorization will remain in effect from the date it is signed until I cancel it in writing.

By signing below, I acknowledge I have reviewed and understand this authorization form.

____ ____
Patient Name **Date**

1070 N. Stone Street, Suite C, Deland, FL 32720 (T) 386-734-1013 (F) 386-734-1028
2776 Enterprise Road, Suite 100, Orange City, FL 32763 (T) 386-774-1223 (F) 386-774-4658
2100 W. First Street, Sanford, FL 32771 (T) 407-323-2250 (F) 407-321-5550